

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/20/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS				STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit [PSR] to the Investigation of Complaint Number IN00099128.</p> <p>This visit was in conjunction with a Post Survey Revisit [PSR] for the Recertification and State Licensure Survey, completed on 12/7/11.</p> <p>Complaint Number: IN00099128 Corrected</p> <p>Survey dates: January 19, 20, 2012</p> <p>Facility number-000155 Provider number-155252 AIM number-100266830</p> <p>Survey team: Diane Hancock, RN, TC Vickie Ellis, RN Amy Wininger, RN Barbara Fowler, RN</p> <p>Census bed type: SNF/NF: 110 Total: 110</p> <p>Census payor type: Medicare: 9 Medicaid: 62 Other: 39 Total: 110</p> <p>Sample: 13</p> <p>Golden Living Center-Woodlands was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regards to the PSR to a the</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 01/20/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS				STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	Continued From page 1 Investigation of Complaint Number IN00099128. Quality review completed 1/23/12 Cathy Emswiller RN			{F 000}			